GRANT REQUEST FOR PROPOSAL

STATE OF WISCONSIN

DEPARTMENT OF HEALTH SERVICES

DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

RFPG # 0292 DMHSAS

Collaborative Crisis Intervention Services to Youth

PROPOSALS MUST BE RECEIVED BY 4:00 PM CT 04/28/14

LATE PROPOSALS WILL BE REJECTED

FAXED PROPOSALS WILL NOT BE ACCEPTED

THE STATE RESERVES RIGHT TO REJECT ANY AND ALL PROPOSALS

1.0 GENERAL INFORMATION

1.1 Summary—Introduction & Background

The Department of Health Services (DHS) represented by the Division of Mental Health and Substance Abuse Services (DMHSAS) invites counties alone or in collaboration with other counties (consortium) to submit a proposal for the development and implementation of programs designed to, at minimum, fulfill the requirements of DHS 34, Subchapter III in the provision of Crisis Intervention Services to Youth. Proposals must encompass approaches that result in improved access, services and outcomes for youth, age birth to 20, who have an apparent severe emotional disturbance (SED).[1] A statewide total of $541,000 annual allocation per year for five years is available for distribution among a minimum of five project awards. Selected proposals will be eligible for continued annual funding, contingent upon successful achievement of annual outcomes that meet federal and state requirements. Achieving the outcomes of this RFP are paramount but to the extent that training is part and parcel to the development of programs, matching Medicaid training funds available at 50 percent are for Medicaid reimbursed Crisis Intervention programs.

1.2 Scope of the Issue

Often, youth suffer silently and go unnoticed until their problems become so great that they expand into other dimensions of their life. Many youth are disinclined to reach out to adults for help and are even less likely to pick up the telephone to reach out to a complete stranger. Rather, the burgeoning sphere of social media is their communication medium. Facebook, chat rooms, and text messaging are where youth can be found discussing some of the most challenging and intimate of life's problems. But that sphere can be difficult for adults to breech; sometimes the only possible detection of problems by adults in a position to help is when the youth is starting to show overt school problems or difficulty getting along with peers. Youth with SED tend to be over-represented in school truancy, drop out, foster care, and Juvenile Justice systems. Beyond these, Child Protective Services (CPS) can also be a nexus to connect with youth experiencing SED. Tragically, youth with SED are disproportionately represented in the homeless and runaway population. To the extent that Crisis Intervention can link with those arenas of a child's life where problems are likely to be first noticed, there is hope that by rendering earlier intervention the child's difficulties can be mitigated and the trajectory toward long-term disability be thwarted. A child with SED who receives too little, too late can not only

[1] See Definitions section.

fall victim to homelessness but also become prone to victimization, drugs or alcohol, sexual abuse, communicable diseases and poor physical health, criminal activity, and many other devastating life events. By the time a youth with SED come to the attention of mental health providers, their situation has deteriorated to the point where more intensive intervention is required. Absent more intensive but less restrictive options, many times psychiatric hospitalization is the only option. Even more tragically, youth can become so distraught and emotionally despairing, coupled with a cognitive trap of hopelessness and helplessness, that they may perceive suicide as the only option.[2]

Hospitalization of Youth

A related concern is that when counties and local providers do encounter a troubled youth, out of concern for safety and liability, psychiatric hospitalization may be seen as the only option. This fact is borne out in the numbers of short-term youth admissions to Winnebago Mental Health Institute (WMHI) for youth who actually do not require inpatient treatment. Unfortunately, removing a child from their school, community and family in order to be hospitalized can have a traumatic effect on the child and family. Moreover, this practice has led WMHI to operate over bed capacity on the juvenile units at WMHI. Additionally, the policy of some private hospitals requiring that parents or guardians be physically present to sign admission documents in order to admit the youth, is leading some youth to be sent to the state institutes unnecessarily.

Hospital census of youth, age 19 and under, at WMHI annually co-varies with the school year.[3] Census is low in the summer and then as the school year commences builds to high points between December and May. Understanding this variation may lead to better practices and interventions to serve these youth outside of inpatient settings.

New Judicial Ruling—Inpatient Medicaid Reimbursement Only for Danger to Self for Youth

Another challenge that faces Crisis providers is that following an Administrative Law judgment in November 2013 with respect to the definition of "emergency services[4]" as defined in

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[2] In Wisconsin, 14 youth age under fifteen died by suicide in the years 2010-11; 224 youth between age 15-24 died by suicide in those same years.

[3] Except for the 18-bed Geropsychiatry unit at MMHI, most all of the DHS's psychiatric civil (as opposed to forensic) beds are being transitioned to WMHI.

[4] DHS Administrative Code 101.03(52): "'Emergency Services'" means those services which are necessary to prevent the death or serious impairment of the individual."

Wisconsin Medicaid. Subsequently, DHS adopted the policy[5] that for the purposes of Medicaid reimbursement[6] for the state IMDs Mendota Mental Health Institute (MMH) or Winnebago Mental Health Institute (WMHI), "emergency services" means those services, which are necessary to prevent the death or serious impairment of the health of the individual. The judicial decision interpreting the administrative rule made it impossible for Medicaid reimbursement for a child who solely presents with danger to others. If the reason for an emergency detention (ED) was that the individual (under age 22) was only a risk to others, then the admission is *not* an emergency under Medicaid standards, thus requiring that the Certificate of Need[7] (CON) must be completed by a physician independent of the institution prior to the admission for the treatment to be Medical Assistance (MA) compensable.

Other Recent Developments

On the other hand, there have been a number of positive developments with respect to serving youth with apparent SED. A Medicaid rule change made it possible for children under 21 years of age to be covered under the outpatient mental health benefit when the services are provided in the home as long as documentation shows the therapeutic reasons why the home is an appropriate location (as compared to the office) to support the youth's recovery (*Forward Health Update* 2013-69[8]). Additionally there is the regional expansion initiative of Comprehensive Community Services (CCS)[9] planned to be implemented in July 2014 as well as the expansion of Coordinated Services Teams (CST).[10]

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[5] DMHSAS Info Memo 2014-02: http://www.dhs.wisconsin.gov/dsl_info/InfoMemos/DMHSAS/CY2014/2014-02InfoMemo.pdf

[6] Wisconsin Medicaid Handbook 101.03(52): http://docs.legis.wisconsin.gov/code/admin_code/dhs/101/101/03/52

[7] DMHSAS/DHCAA Info Memo 2009-02: http://www.dhs.wisconsin.gov/dsl_info/numberedmemos/DMHSAS/CY2009/nmemo200902.htm and form: http://www.dhs.wisconsin.gov/forms/F1/F11047.pdf

[8] Forward Health Update 2013-69: https://www.forwardhealth.wi.gov/kw/pdf/2013-69.pdf

[9] Comprehensive Community Services (CCS) Expansion: http://www.dhs.wisconsin.gov/mh_bcmh/ccs/expansion/index.htm

[10] DMHSAS Numbered Memo 2013-07 on CST Expansion Funding: http://www.dhs.wisconsin.gov/mh_bcmh/CST/ActionMemo201307.pdf

It is the intent of this proposal solicitation to build on the strengths of existing infrastructure and programs, learning from what has worked effectively and what has not, both in terms of provider experience as well as the growing base of evidence-based and best practices. The particular focus and approaches used by each Proposer will be unique to the assessed local needs toward addressing remaining barriers—especially as they pertain to youth.

1.2.1 Prior Rounds of Funding.

Grant efforts to develop and enhance Crisis Intervention programs have been underway for more than five years. These have enhanced access and availability of Crisis Intervention resources, which aimed at reducing psychiatric inpatient hospitalizations and reducing lengths of stay statewide. The number of DHS 34, Subchapter III certified programs grew substantially over the grant period; overall, the data show psychiatric hospitalizations did decrease for both children and adults but not robustly for children. The data contain shortcomings, however (e.g., measuring largely state institute data and often neglecting private hospitalization data). Additionally, measuring hospitalizations has been confounded by a lack of standardization around reporting hospitalizations verses emergency department (ED) visits. Without including the ED visits in some regions (e.g., Milwaukee), the total number of hospitalizations was not captured.

1.2.2 Experiential Results of the Current Round of Funding.

Crisis Intervention programs were surveyed to identify important factors in the achievement of prior DHS statewide goals. Those goals include, but are not limited to, reducing hospitalizations, decreasing length of stay, increasing diversions from inpatient hospitalization, and increasing community stabilization options. Follow-up discussions and conference calls reviewing the data shed additional light on the impactful factors and practices. Below are two examples of some of the important factors necessary to achieve our goals:

Reducing the Number of Psychiatric Hospitalizations. Programs noted that the factors, which resulted in reduction of inpatient psychiatric hospitalization, include the following (in no particular order):

- Collaboration with law enforcement and hospitals
- Coordinating between providers; regional agreements; monthly meetings with physicians
- Meeting regularly with psychiatrists
- Training crisis staff, law enforcement agencies, and hospitals

- Development of infrastructure with mobile crisis teams, crisis lines, hiring additional staff, and developing or expanding crisis diversion and diversion beds
- In-person assessments for all potential emergency detentions
- Supervising complex emergency detentions
- Having individual Crisis Plans
- Using active outreach to natural support
- Providing near-term follow-up (within a week)
- Use of Plan-Implement-Execute (PIE)[11,12] or NIATx (Network for the Improvement of Addiction Treatment)[13] practices

Continuing challenges to reducing hospitalizations include:

- Legal barriers and liability issues
- Lack of regional communication
- Lack of formal diversion process or infrastructure
- Lack of alternative options for certain populations (i.e., children and youth, adults with dementia, and intoxicated person)
- Matching the correct and appropriate intervention to the right person (e.g., persons who self-mutilate as opposed to those who are suicidal).
- Confounded or imprecise, operationally defined data

It is important to note that inpatient census for youth have been over bed capacity at the state mental health institute (Winnebago Mental Health Institute) during the school year for at least the last two years. Longer lengths of stay may result from some children being admitted at a point when their condition is more severe may account for part of the increased demand for beds. However, it is the experience of the clinical staff at WMHI that a greater impact is due to children being hospitalized unnecessarily, when this more intensive and dramatic intervention is unwarranted. Other challenges for some of the more severely disturbed children involve

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[11] SPRC Plan, Implement, Evaluate, Improve: http://www.sprc.org/basics/about-suicide-prevention/strategic-planning/implement-evaluate-and-improve-interventions

[12] Centers for Disease Control: Planning Implementing, and Evaluating an Intervention—An Overview: http://www.cdc.gov/violenceprevention/pdf/chapter1-a.pdf

[13] NIATx Website: Removing Barriers to Treatment & Recovery: http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME

finding post-hospitalization resources and residential placements that will accept the child. More effective and earlier community intervention to serve children with less serious conditions outside of the hospital and before their condition deteriorates, would relieve some of the burden to the state mental health institutes. At the same time, more effective crisis diversion services might result in being able to focus on children with more acute and severe conditions for admittance to hospitals, and appropriately so.

Reducing Psychiatric Inpatient Length of Stay. Crisis Programs identified the following as effective in reducing length of stay:

- Infrastructure, such as having diversion beds or beds for substance use disorder
- Practices such as having:
    - Crisis staff conduct interviews in the hospital
    - Improving communication with hospital staff and other counties
    - Regular follow-up with clients (within 24 hours, 14 days, 30 days, etc.)
    - Commitment authorization being rendered by a clinical person

Barriers include:

- Lack of information and standard practices for doctors, attorneys and Corporation Counsel
- Insufficient community resources to receive homeless individuals or those with behavioral challenges

1.2.3 Focus Population and Duration of Projects.

This round of Crisis Grant funding will focus on building capacity to serve youth and strengthening partnerships in youth service systems. It will necessitate robust follow-up, linkage and coordination activities to support youth in the transition from Crisis, hospital, or diversion, toward longer- term follow-up. However, capacity development can range broadly. It might mean developing DHS 34, subchapter III coverage for a county not previously serviced by such a Crisis Program. It might mean developing staff to a greater level of competence in youth culture and becoming proficient at the assessment and management of youth suicide risk. It might mean convening regular Crisis meetings in collaboration with the leadership of other agencies such as law enforcement, hospitals, juvenile justice, corporation counsel, homeless/runaway providers, Coordinated Service Teams (CST), and others.

Proposed responses to this RFP will allow counties, multi-county consortia, or regions the means to address challenges unique to their particular service area. Proposals must encompass

approaches that will provide improved services and outcomes to youth, age birth to 20, who have an apparent severe emotional disturbance (SED).[14] The Crisis rule (DHS 34) does not require that a person actually carry a diagnosis of a mental disorder but rather exhibit an *apparent* mental disorder.[15] Crisis staff are not required to function in the capacity of diagnosticians; instead their charge is to help address or mitigate an existing crisis or to prepare a, "Crisis plan" for an individual at *high risk of experiencing a mental health crisis.* Equipped with a plan, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs. Like prior grant efforts to Crisis programs established in five-year timeframes, the present grant initiative will be set in a five-year timeframe, contingent upon successful deliverable outcomes in semi-annual and annual intervals. The present round of funding will look for objective outcomes set within a more rigorous data-reporting environment.

1.2.4 Minimum Requirements.

The following requirements are the minimum specifications and responsibilities. If no Proposers are able to comply with any given specification, condition of proposal or provide a specific item, the state reserves the right to delete that specification, condition of proposal or item. Proposers must demonstrate the following requirements as part of their proposal:

- Use of data-driven, Plan-Implement-Execute (PIE) or NIATx-type rapid-cycle improvement strategies.
- If a Coordinated Services Team(s) (CST)[16] exists in Crisis service area, then the Crisis program(s) must collaborate with the CST ultimately developing a memorandum of understanding (MOU) for reciprocal partnership in service and referral.
- Have a specific plan to assure accurate, complete, and prompt reporting for Crisis Intervention into the state Program Participation System (PPS)[17] and for complying with the other reporting requirements of the grant. Specifically, within 45 days of the start of

[14] See Definitions section.

[15] See Definitions Section

[16] State funding is being made available to allow all counties to have CST programs. DMHSAS CST Action Memo 2013-07: http://www.dhs.wisconsin.gov/mh_bcmh/CST/ActionMemo201307.pdf

[17] Wisconsin Department of Health Services, Program Participation System (PPS): http://www.dhs.wisconsin.gov/pps/

the grant, Proposers must have a planned implementation mechanism to assure that all requisite PPS data are captured and properly reported into PPS on an ongoing basis.

- Report into PPS all Crisis Intervention contacts.
- Report into PPS all psychiatric hospitalizations (both private and public, and state institutes) that involve a Crisis Intervention contact.
- Report on all diversions (see Appendix D) from psychiatric hospitalization that involves Crisis Intervention contact, including dates of stay and the age of the client.
- Report into PPS all post-hospitalization and/or post-residential stabilization follow-up for clients that had Crisis Intervention contact.

All proposals must include a plan to assure that the "Coordinated Emergency Mental Health Services Plan"[18] for the Crisis Intervention program(s), is amended and updated within the first nine (9) months of the start of the grant.

Statutory Authority. Under statutory authority of Chapter 46.485[19] projects proposed by counties (or in collaboration or in region) must describe strategies to develop and enhance community-based DHS-34, Subchapter III Crisis Intervention services for youth with an apparent serious emotional disturbance (SED). As an essential component of this effort, Crisis Programs must establish collaborative partnerships with programs designed to serve youth with SED that have a central service coordination component (e.g., Comprehensive Community Services [CCS], Community Support Program [CSP], children's wraparound, Children's Long Term Care [CLTS] waiver services, Developmental Disability [DD] services, residential treatment, etc.). Collaboration and partnership with children's Coordinated Services Teams (CST) is a requirement. There must be a reciprocal working relationship between the Crisis Program and care coordination agencies such that referrals to and from the Crisis Intervention Program are effected seamlessly with sufficient follow-up. While training may be a component of the present project, it is expected that the vigorous efforts will be placed on directly addressing

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[18] Coordinated Emergency Mental Health Services Plan in DHS Administrative Rule 34.22(1): https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/34/III/22/1

[19] Chapter 46.485 and Appropriation Accounts under s. 20.435(4)(b) and (gp) the department may in each fiscal year transfer funds to the appropriation under 20.435(7)(kb) for:

(a) Mental health care and treatment, other than care and treatment under s. 51.35(3) [transfer of juveniles from secured juvenile facilities] in an inpatient facility for children with severe emotional disturbances.
(b) Community mental health services for children with severe emotional disturbances.

For additional details, please see: http://docs.legis.wisconsin.gov/statutes/statutes/46/485/1/d

gaps in coordination and service delivery to youth in a variety of agencies that touch a child's life.

1.2.5 Alignment With Mission and Priority.

This project brings into convergence a number of perspectives that support the federal mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) to reduce the impact of substance abuse and mental illness on America's communities. It encompasses SAMHSA's eight identified strategic initiatives[20] to achieve a high quality, self-directed, satisfying life, integrated in the community through four essential dimensions in life:

a) *Health*, overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
b) *Home*, a stable and safe place to live that support recovery;
c) *Purpose*, Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, as well as the independence, income, and resources to participate in society; and
d) *Community,* Relationships and social networks that provide support, friendship, love and, hope. Moreover, it supports the three domains of prevention,[21] treatment and recovery.

This project also aligns with the DHS Mission, "to support economic prosperity and quality of life, the Department of Health Services exercises multiple roles in the protection and promotion of the health and safety of the people of Wisconsin."[22] Additionally it embraces the mission of DMHSAS, to "provide services to the people of Wisconsin and support the development of services and systems which are recovery focused, person- and family - centered, supportive of

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[20] Leading Change: a Plan for SAMHSA's Roles and Actions 2011-2014: http://store.samhsa.gov/shin/content//SMA11-4629/01-FullDocument.pdf

[21] Preventing Mental, Emotional, and Behavioral Disorders Among Young People: http://www.iom.edu/~/media/Files/Report%20Files/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People/Preventing%20Mental%20Emotional%20and%20Behavioral%20Disorders%202009%20%20Report%20Brief%20for%20Policymakers.pdf

[22] Wisconsin DHS Mission Statement and Guiding Principles: http://www.dhs.wisconsin.gov/aboutdhs/oos/fundamentals.htm and http://www.samhsa.gov/co-occurring/news-and-features/strategic-initiatives.aspx

client rights, evidence-based, and cost-effective… [And to] promote an atmosphere of accountability through performance outcomes; utilize data to inform our policy and decision-making... [And to] improve the efficiency of operations within DMHSAS and in our collaborations statewide."

The RFP is framed around the three levels of preventative intervention[23] as described by the Institute of Medicine (IOM). Most apparent is that this initiative is aimed especially at "selective" and "indicated" prevention.[24]

Moreover this project aligns with the top-ranked needs in the *Wisconsin Mental Health and Substance Abuse Needs Assessment* as well as the priorities of the proposed Wisconsin 2014-15 Combined Mental Health/Substance Abuse Block Grant[25] application. At the federal level, there is new emphasis on early intervention, specifically for evidence-based programs addressing the needs of individuals with the early signs of serious mental illness.[26]

1.2.6 Environmental Scan and Needs Assessment.

Proposers should determine the scope of the proposal (county, region, multi-county partnership) and then provide a needs assessment outlining strengths, deficits, and barriers for the identified service area regarding access to children's mental health services and their unmet needs in emergency or crisis services. Items to focus on include the access and availability of mental health and substance use disorder providers, inpatient resources, diversion resources and nexus points (such as law enforcement, schools, etc.) for connecting with youth who may have SED.

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[23] SAMHSA Levels of Risk and Levels of Intervention: http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/levels-risk-levels-intervention/2

[24] SAMHSA Levels of Risk and Intervention Fact Sheets: http://captus.samhsa.gov/sites/default/files/capt_resource/capt_behavioral_health_fact_sheets_2012_0.pdf

[25] Wisconsin Council on Mental Health Combined Mental Health and Substance Abuse Block Grant Draft: http://www.mhc.state.wi.us/docs/MHBG/2013/2014CombinedBGExecutiveSummary021413.pdf

[26] Library of Congress Committee Reports: http://thomas.loc.gov/cgi-bin/cpquery/?&sid=cp1132kIPg&r_n=sr071.113&dbname=cp113&&sel=TOC_365184&

1.3 Procuring and Contracting Agency

The Department of Health Services, Division of Mental Health and Substance Abuse Services issued this RFP. DMHSAS will administer any contract resulting from this RFP. The Contract Administrator will be:

Brad Munger (or Designee)

Program and Planning Analyst—Advanced

Department of Health Services

Division of Mental Health and Substance Abuse Services

1 W. Wilson Street, Room 851

Madison, WI 53704

1.4 Definitions

Throughout the RFP, the following terms are defined as:

1) **ADA Accessible: Americans with Disability Act (ADA)** is a comprehensive, federal civil rights law that prohibits discrimination on the basis of disabilities in employment, state and local government programs and activities, public accommodations, transportation, and telecommunications. Accessible: refers to a site, facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability.
2) **AAS:** American Association of Suicidology[27]
3) **Annual:** Grant years refer to the period July 1, 2014 to June 30, 2015. Subsequent annual grant years are for the subsequent 12-month periods.
4) **AODA:** Alcohol and Other Drug Abuse now referred to as Substance Use Disorder.
5) **Applicant:** the legal entity that assumes the liability for the administration of the grant funds and is responsible to DHS for the performance of the project activities.
6) **BPTR:** Bureau of Prevention Treatment and Recovery in the Division of Mental Health and Substance Abuse Services in the Wisconsin Department of Health Services.
7) **Certified Peer Specialists:** Sometimes referred to as "CPS" (not to be confused with Child Protective Services), these are individuals with lived mental health experience trained and certified as peer specialists that provide information and peer support. Certified Peer

[27] AAS: www.suicidology.org

Specialists perform a wide range of tasks to assist members in regaining control over their own lives and over their own recovery process. Peer specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through: lending their unique insight into mental illness and what makes recovery possible and helping service recipients understand recovery and achieve their own recovery needs, wants, and goals; advocate for service recipients so that individuals may make their own decisions in all matters when dealing with professionals; engage and encourage mental health service recipients in recovery; promote wellness, independent living, self-direction, and recovery focus, enhancing the skill and ability of service recipients to meet their chosen goals; work with service recipients as equals except in having more recovery experience and training, looking for and empowering signs of wellness and recovery, encouraging strength and self-direction**.**

8) **Children's Long-Term Support Program (CLTS):** Home and Community-Based Medicaid Waivers (CLTS Waivers) provide a structure to support children who are living at home or in the community and who have substantial limitations in multiple daily activities as a result of one or more of the following disabilities: developmental disabilities, severe emotional disturbances, and physical disabilities. Funding can be used to support a range of different services that are identified based on an individual assessment of the child and his or her needs.[28]
9) **Child Protective Services (CPS):** To protect the health, safety, and welfare of children by encouraging the reporting of suspected child abuse and neglect; To assure that appropriate protective services are provided to abused and neglected children and their families and to protect children from further harm; To provide support, counseling, and other services to children and their families to ameliorate the effects of child abuse and neglect; To promote the well-being of the child in his or her home setting, wherever possible, or in another safe and stable placement.[29]
10) **Community Support Program (CSP):** Under DHS administrative rule 63, CSP means a coordinated care and treatment program which provides a range of treatment, rehabilitation and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation and support services in the community for persons with severe and persistent mental illness.
11) **Comprehensive Community Services (CCS):** Under DHS administrative rule 36, a county−wide or tribal community−based psychosocial rehabilitation program that is

[28] CLTS: http://www.dhs.wisconsin.gov/children/clts/

[29] Wisconsin Department of Children and Families: http://dcf.wisconsin.gov/children/cps/

operated by a county department or tribe to provide or arrange for the provision of psychosocial rehabilitation services.

12) **Coordinated Services Team (CST):** Under Wisconsin Statutes 45.56,[30] a CST is a group of individuals, including family members, service providers, and informal resource persons, who work together to respond to service needs of a child who is involved in 2 or more systems of care and his or her family.
13) **Consortium:** An application covering more than one county, Unified Services Board/Human Service Department or Tribal governing body.
14) **Continuity of Operations Plan (COOP):** An effort within individual executive departments and agencies to ensure that Primary Mission Essential Functions (PMEFs) continue to be performed during a wide range of emergencies, including localized acts of nature, accidents and technological or attack-related emergencies.
15) **Crisis:** "'Crisis' means a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual." DHS 34.02(5)
16) **Crisis Intervention**: Under administrative rule DHS 34,[31] Crisis Intervention or "Emergency mental health services" means a coordinated system of mental health services which provides an immediate response to assist a person experiencing a mental health crisis.
17) **Culture:** The shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, language, nationality, or religion.
18) **Cultural Competence:** A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community.
19) **Department / DHS**: the Wisconsin Department of Health Services.
20) **Diversion:** Diversion occurs when an adult or child who is involved with Crisis Intervention,[32] within 48 hours of the time of the encounter, as a result of Crisis

[30] Wisconsin Statutes Chapter 46.56: https://docs.legis.wisconsin.gov/statutes/statutes/46/56/14/e

[31] Wisconsin DHS 34 Administrative Rule: http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/34.pdf

Intervention services is *diverted* to a less intensive[33] setting that is more appropriate to their clinical need instead of being admitted to a behavioral health hospital.[34] (see Appendix D).

21) **Division**: Unless otherwise stated "Division" represents the Division of Mental Health and Substance Abuse Services.
22) **DMHSAS**: the Division of Mental Health and Substance Abuse Services that administers mental health and substance abuse policy in Wisconsin.
23) **DOA:** the Wisconsin Department of Administration.
24) **Ethnic:** Belonging to a common group—often linked by race, nationality and language--with common cultural heritage and/or derivation.
25) **Functional Assessment Service Team (FAST) Training**: In a disaster or emergency response scenario, FAST teams support shelter residents with access and functional needs. Functional Assessment Service Teams provide a system for assessing people with access and functional needs when they enter the reception center or shelter and helping them get what they need to safely stay there.
26) **Grant-/Sub- Recipients**: Vendor awarded funds for direct benefit of the community.
27) **HIPAA:** the Health Insurance Portability and Accountability Act of 1996.
28) **IMD:** Institute for Mental Disease is a free standing psychiatric hospital that is not part of a general medical hospital. IMDs are institutions primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. In 1988, the definition of IMDs was narrowed to only those facilities with more than 16 beds. When the Medicaid program was established in 1965 the *IMD exclusion* prohibited Medicaid from making payments to IMDs for services rendered to Medicaid beneficiaries aged 21 to 64.
29) **Language:** The form or pattern of speech—spoken or written—used by residents or descendants of a particular nation or geographic area or by any large body of people. Language can be formal or informal and includes dialect, idiomatic speech, and slang.
30) **LGBT:** Lesbian, Gay, Bisexual, Transsexual, each of which have unique cultural aspects that must be respected and understood.

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[32] Crisis Intervention Involvement is defined as having Crisis contact requiring an open clinical record and requisite reporting into the PPS data system.

[33] Congruent with responsibilities to treat in the least restrictive setting.

[34] For this definition, "behavioral health hospital" shall include inpatient psychiatric units in a general hospital, free-standing Institutes of Mental Disease (IMDs), and inpatient hospital treatment for substance use disorder.

31) **MMHI:** Mendota Mental Health Institute is an IMD operated by the State of Wisconsin Department of Health Services.
32) **MOU:** Memorandum of Understanding
33) **NIATx:** *Network for the Improvement of Addiction Treatment* is an easy to use model of process improvement designed specifically for behavioral health.[35]
31) **Outpatient Mental Health Clinic:** Under administrative rule DHS 35,[36] an entity that is required to be certified in order to receive reimbursement for outpatient mental health services to consumers.
32) **Peer/Recovery Support Services:** are services provided in domains supporting an individual's health, home, purpose, and community; designed and delivered by persons who have the lived experience of mental illness and/or substance abuse disorders. These services promote recovery, a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
33) **PIE—Plan, Implement, Evaluate:** A model of rapid cycle quality improvement.[37]
34) **Post-Vention:** The provision of crisis intervention and other support after a suicide has occurred to address and alleviate possible effects of suicide.
35) **Program Participation System (PPS):** A web-based information technology system developed to streamline various program reporting functions and tasks for the public behavioral health sector.
36) **Proposal:** Response to RFP
37) **Proposer:** an entity responding to this RFP.
38) **RFP:** is defined as Request for Proposal.
39) **SAMHSA**: Federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
40) **SED:** "Severely Emotionally Disturbed Child" means an individual under age 21 years of age who has emotional and behavioral problems that: (1) are severe in degree; (2) are expected to persist for at least one year; (3) substantially interfere with the individual's functioning in his or her family, school or community and with his or her ability to cope with the ordinary demands of life; and (4) cause the individual to need services from two or more agencies or organizations that provide social services or services or treatment for mental health, juvenile justice, child welfare, special education or health.

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[35] NIATx: http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME

[36] Wisconsin Administrative Rule DHS 35: http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/35.pdf

[37] PIE and Logic Model Improvement: http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

41) **SPRC:** Suicide Prevention Resource Center.[38]
42) **State:** the State of Wisconsin.
43) **Subcontract:** A written agreement between the contractor and a subcontractor to provide services.
44) **Subcontractor:** A third party who contracts with the awarded contractor for the provision of services, which the contractor has contracted with the Department to perform.
45) **WMHI:** Winnebago Mental Health Institute is an IMD operated by the State of Wisconsin Department of Health Services.
46) **Youth:** Individuals between the ages of birth through age 20, encompassing the ages defined for SED.

1.5 Clarification and/or Revisions to the Specifications and Requirements

Any questions concerning this RFP must be submitted to: Brad Munger, Program and Planning Analyst-Advanced, for DMHSAS at BradMunger@Wisconsin.gov.

Written questions must be submitted before 4:00 p.m. Central Time on Wednesday, April 2, 2014. Questions should be submitted via email with the following subject line:

Subject: Question *RFPG # 0292 DMHSAS,* Proposer Name

Telephone questions will not be accepted. Any oral responses, information, dates, and/or technical assistance received by a prospective Proposer from the Department or Department staff shall not, in any manner whatsoever whether before or after the release of this RFP, be binding on the State of Wisconsin, unless followed-up and explicitly confirmed and stated in writing by the State.

Proposers are expected to raise any questions, exceptions, or additions they have concerning the RFP document at this point in the RFP process. If a Proposer discovers any significant ambiguity, error, conflict, discrepancy, omission, or other deficiency in this RFP, the Proposer should immediately notify the *Contract Administrator* of such error and request modification or clarification of the RFP.

In the event that it becomes necessary to provide additional clarifying data or information, or to revise any part of this RFP, revisions/amendments and/or supplements will be provided to

[38] SPRC: www.sprc.org

those entities that have completed the Notice of Intent to Apply procedure referenced in section 2.5.

Contact with State employees and/or members of the review committee concerning this RFP is prohibited except as authorized by the Contract Administrator during the period from date of release of the RFP until the notice of intent to award is released.

1.6 Contract Quantities / New or Deleted Items

The procuring and contracting agency does not guarantee to purchase any specific quantity of services. Proposals that state that the purchasing agency must guarantee a specific quantity or dollar amount may be disqualified.

The contractor shall not have exclusive rights to provide all services covered under this contract during the term of the contract or any extension of the contract.

1.7 Reasonable Accommodations

DHS will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities upon request. If you think you need accommodations at any time during the RFP process, contact Brad Munger, Program and Planning Analyst-Advanced, at 608-266-2754 or Brad.Munger@Wisconsin.gov.

1.8 Calendar of Events

The table below lists specific and estimated dates and times of actions related to this RFP. The actions with specific dates must be completed as indicated unless otherwise changed by the State. In the event that the State finds it necessary to change any of the specific dates and times in the calendar of events listed below, it will do so by issuing a notice to those entities who have submitted a Notice of Intent to Apply as detailed in section 2.5. There may or may not be a formal notification issued for changes in the estimated dates and times.

DATE	EVENT
3/7/14	RFP Posted to DHS Website
3/31/14	Proposer's Conference
04/2/14	Deadline for Written Questions
4/7/14	All Questions and Answers Posted to DHS Website
4/9/14	Notice of Intent to Apply Due*
Monday, April 28, 2014 **at 4:00 p.m. Central Time**	**Proposals Due**
5/16/14	Notification of Intent to Pursue Contract Negotiations
6/6/14	Contract Execution Date
July 1, 2014	Contract Start Date

***Optional**

1.9 Proposer Conference

A proposers telephone conference will be held on Monday, March 31, 2014 from 8:00 to 10:00 a.m. The call-in number will be 1-877-820-7831 (passcode: 123398). Attendees are able to attend in person as well at the DHS Central Office at 1 W. Wilson St. in Madison, Wisconsin. At present the scheduled room is 751 (subject to change).

1.10 Contract Term and Available Funding

The contract shall be effective on the date indicated in the contract and shall run for one year from that date with an option by mutual agreement of the Department and contractor, to renew for four (4) additional one-year periods. The statewide total amount of funds available through this RFP is $541,000 for each approved contract year.

Additionally, each contract is eligible for federal Medicaid funding for Crisis training that meet federal training requirements. Each region should determine their total training budget for their proposal and then determine how much of their budget is eligible for federal reimbursement, based on Title 42, Part 432 of the federal statutes. Fifty (50) percent of the total funds spent on eligible training programs will be eligible for reimbursement by Medicaid. Proposal budgets should include these federal funds.

Renewal of the contract for years two, three, four, and five will be based upon the Proposer's satisfactory performance and reporting, audit findings and the availability of funds. Following the fifth year of funding, the expectation is the project will be self-sustaining through the development of systems infrastructure, enhanced revenues and cost efficiencies stemming from the project. The successful applicant must demonstrate its plan for sustainability beyond the funding period. Proposers are advised that should additional state or federal funds become available, the Division may utilize the results of this RFP for additional awards. Moreover, the Department reserves the right to negotiate with the successful bidder(s) separate cost reimbursement for additional work that is related to 2013 Wisconsin Acts 126, 127, 128, 130, or 132, or other state or federal initiatives.

1.11 Retention of Rights

The State of Wisconsin retains the right to accept or reject any or all proposals if it is deemed to be in the best interest of the State of Wisconsin.

If mutually agreed to by the contractor and the State, the results of this solicitation may be used by other Wisconsin agencies or other states.

All proposals become the property of DHS upon receipt.

1.12 Who May Submit an Application

Existing Crisis Intervention regional collaborations may submit a proposal under their current structure. However, recognizing that the resources and needs of different counties and parts of the state are unique, proposals will be accepted from county[39] human services programs,

[39] **Wisconsin Stats. 46.485(2g)** "From the appropriation account under s. 20.435 (4) (b), the department may in each fiscal year transfer funds to the appropriation account under s. 20.435 (5) (kc) for distribution under this section and from the appropriation account under s. 20.435 (7) (mb) the department may not distribute more than $1,330,500 in each fiscal year to *applying counties* in this state that meet all of the following requirements…[emphaisis added]"

departments of community programs, county partnerships or consortiums in the state of Wisconsin.

2.0 PREPARING AND SUBMITTING A PROPOSAL

2.1 General Instructions

The selection of a contractor is based on the information submitted in the contractor's Proposal. Failure to respond to each of the requirements in the RFP may be the basis for rejecting a Proposal.

Elaborate Proposals (e.g., expensive artwork), beyond what is sufficient to present a complete and effective Proposal, are not necessary or desired.

The State of Wisconsin is not liable for any cost incurred by Proposers in replying to this RFP.

Proposers must submit Proposals in strict accordance with the requirements set forth in this section. All materials must be submitted to:

Brad Munger
Planning and Program Analyst--Advanced
Department of Health Services
Division of Mental Health and Substance Abuse Services
1 W. Wilson Street, Room 851
Madison, WI 53701-7851
(608) 266-2754

All materials must be received in the prescribed formats by **Friday, 4/28/14 at 4:00 p.m. Central Time.**

Proposals must be received in the above office by the specified date and time. Receipt of a Proposal by the State mail system does not constitute receipt of a Proposal. No Proposals are allowed to be submitted by fax or email. All such Proposals will be rejected.

There are two components needed for complete submission of the Proposals: Paper (Hard Copies) and Electronic. Both components are due to the address above by the stated date and time. The following submission requirements must be followed for each of the components:

Paper (Hard Copy) Proposal Component

This component must contain the original and six (6) paper copies of the entire Technical Proposal (see Section 2.2 Proposal Organization and Format) including any proprietary information. Proposals shall be submitted in 12-point standard font with single-spacing and one-inch margins.

Electronic Proposal Component

In addition to the paper documents described above, the entire Proposal must be submitted in non-password protected Portable Document Format (.pdf), (except for the proposed budget, which must be submitted using the required Microsoft Excel template) on a reproducible CD(s) labeled as follows:

Collaborative Crisis Intervention Services to Youth

Name and Address of Proposer

RFP 0292 DMHSAS

Disc X of Y

2.2 Proposal Organization and Format

Technical proposals must be organized into clearly delineated sections, as shown below. Each heading and subheading should be separated by tabs or otherwise clearly marked.

Tab 1. Cover Sheet

a. Table of Contents

b. Vendor Information Form DOA-3477

Tab 2. Goals, Objectives and Performance Expectations – Section 6.1

Tab 3. Environmental Scan, Needs Assessment, and Program Design and Methodology – Section 6.2

Tab 4. Work Plan – Section 6.3

Tab 5. Organizational Experience and Capacity– Section 6.4

Tab 6. Reporting, Performance Measurement & Quality Improvement – Section 6.5

Tab 7. Budget – Section 7.0

Tab 8. Appendix – Letters of Support, Letters of Commitment, Memorandums of Understanding, Contracts, etc.

All materials must be received in the prescribed formats by Friday, 4/28/14 at 4:00 p.m. Central Time.

2.2.1 Transmittal Letter.

A Transmittal Letter must accompany the RFP package. It must be on official business letterhead of the Proposer submitting the Proposal, and must be signed in ink by an individual authorized to legally bind the vendor.

The Transmittal Letter must stipulate the following:

- The Proposer is the primary Vendor and is a corporation or other legal organization;
- Services that the Vendor intends to sub-contract to another entity;
- No attempt has been made or will be made by the Vendor to induce any other person or firm to submit or not to submit a Proposal;
- The vendor certifies they have neither directly nor indirectly entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that this Proposal has been independently arrived at without collusion with any other Vendor, competitor or potential competitor; that this proposal has not been knowingly disclosed prior to the opening of proposals to any other vendor or competitor.
- A *Statement of Qualifications* that the vendor is able to meet all the Mandatory Requirements and Special Terms and Conditions in Sections 4.0.
- The Proposal is valid for a minimum of 60 Days from the Proposal due date;
- The person signing this letter and all RFP documents is authorized to make decisions on behalf of the Proposing organization and that the person has not participated, and will not participate, in any action contrary to the this statement;
- Assurance that the vendor will agree to execute and fulfill a contract according to the conditions and terms specified in this RFP;
- That the Proposal is predicated upon the requirements, terms, and conditions of this RFP, the posted Questions and Answers, all its attachments, and any supplements or revisions thereof; and
- That an individual authorized to bind legally the vendor has signed this Transmittal Letter.

2.3 Multiple Proposals

Submission of multiple Proposals from Proposers is not permissible.

2.4 Withdrawal of Proposals

Proposals shall be irrevocable until contract award unless the Proposal is withdrawn. Proposers may withdraw a Proposal in writing at any time up to the Proposal closing date and time or

upon expiration of five (5) business days after the due date and time if received by Brad Munger. The written request must be signed by an authorized representative of the Proposer and submitted to Brad Munger at the address listed in Section 2.1 General Information. If a previously submitted Proposal is withdrawn before the Proposal due date and time, the Proposer may submit another Proposal at any time up to the Proposal closing date and time.

2.5 Notice of Intent to Apply

Prospective Proposers are requested, but not required, to submit a notice of intent to apply to the Division. The notice of intent should be submitted to the Division at the mailing address below by **4:00 PM Central Time on Friday, 4/08/14.** Submission of the notice of intent does not commit a prospective Proposer to submission of a Proposal.

Any supplemental written information related to this RFP developed by the Division will be provided only to those agencies who have filed a Notice of Intent, or to agencies who request such information. Notices should be mailed, emailed, faxed, or hand delivered to:

Brad Munger
Program and Planning Analyst--Advanced
Division of Mental Health and Substance Abuse Services
1 W. Wilson Street, Room 851
Madison, WI 53703
Fax: (608) 266-2754
Email : Brad.Munger@Wisconsin.gov

3.0 Proposal Selection and Award Process

3.1 Preliminary Evaluation

The purpose of the preliminary evaluation is to determine if each Proposal is sufficiently responsive to the RFP to permit a complete evaluation. Proposals must comply with the instructions to Proposers contained in this RFP. Failure to comply with the instructions may cause the Proposal to be rejected without further consideration. The state reserves the right to waive any minor irregularities in the Proposal.

3.2 Proposal Scoring

Proposals accepted through the preliminary evaluation process are reviewed by an evaluation committee and scored against chosen criteria. A Proposer may not contact any member of an evaluation committee except with the *Contract Administrator's* written approval.

3.3 Proposal Evaluation Criteria

The proposal evaluation committee will review all proposals against stated criteria. Proposals from eligible applicants will be scored according to the following competitive criterion:

Maximum Points (100 Total)

PROPOSAL EVALUATION CRITERIA	MAXIMUM POINTS
• Goals, Objectives and Performance Expectations	**20 points**
• Program Design and Methodology	**25 points**
• Work Plan	**15 points**
• Organizational Experience and Capacity	**10 points**
• Reporting, Performance Measurement and Quality Improvement	**15 points**
• Budget	**15 points**
TOTAL	**100 points**

a. Notification of Intent to Pursue Contract Negotiations

All Proposers who respond to this RFP will be notified via email of the State's intent to pursue contract negotiations as a result of this RFP.

b. Right to Reject Proposals and Negotiate Agreement Term

The State reserves the right to reject any and all Proposals. The State may negotiate the terms of the contract, including the award amount, with the selected Proposers prior to entering into a contract. If contract negotiations cannot be concluded successfully with the recommended Proposer or upon unfavorable review of the Proposer's references, the Department may terminate contract negotiations.

The Contract Administrator or designee will review each RFP Response Package and Statement of Proposer Qualifications to verify the Proposer meets the requirements specified in this RFP based on a pass or fail protocol. This determination is the sole responsibility of the Department.

c. Letters of Support

Proposers are encouraged to submit letters of support. Letters may originate from stakeholder organizations, partner agencies, businesses, educational institutions, and/or other health and human service provider agencies. Letters of support should address the potential for success in providing mental health and substance abuse programming in a shared services delivery system. The evaluation committee will consider letters of support in review of the proposals.

4.0 MANDATORY REQUIREMENTS

To be eligible for further evaluation consideration Proposers must certify their ability to meet all *MANDATORY REQUIREMENTS* as specified. Additional requirements may apply upon contract execution specific to the services provided.

4.1 Proposal Format, Electronic Data Base/Spreadsheet Reporting

Proposers are required to submit their proposal in single-sided, single-spaced, 12-point standard font (prefer Times New Roman), with a minimum of 1-inch margins. Please limit proposals to 20 pages, not including budget, appendices, and letters of support. Budgets are to be submitted on the required Excel spreadsheet specified in Appendix B. The work plan is required to be coordinated with the budget and the performance monitoring reporting tool specified in Appendix C. For the overarching goals and objectives of this project, defined herein, data will be reported either into the PPS or on an Excel spreadsheet for those data not captured in PPS.

4.2 Statutory requirements

Under statutory authority of Chapter 46.485[40] projects proposed by counties (or counties in collaboration or regions) must describe strategies to develop and enhance community-based certified DHS-34, Subchapter III Crisis Intervention services for youth with apparent serious emotional disturbance (SED).

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[40] Chapter 46.485 and Appropriation Accounts under s. 20.435(4)(b) and (gp) the department may in each fiscal year transfer funds to the appropriation under 20.435(7)(kb) for:

(c) Mental health care and treatment, other than care and treatment under s. 51.35(3) [transfer of juveniles from secured juvenile facilities] in an inpatient facility for children with severe emotional disturbances.
(d) Community mental health services for children with severe emotional disturbances.

4.3 Requirement #3 Administrative Rule, Licensure, Certifications, Locations

All efforts within the current project will be to further develop and promote certified DHS 34, Subchapter III, Medicaid-reimbursable services statewide in the context of Wisconsin Chapters 51, 48, 938, and 46, as well as the Department of Public Instruction (DPI). Required is collaboration with Coordinated Services Teams (CST) for children (Wisconsin Chapter 46.56) insofar as they exist in the Crisis service area.

4.4 Patient's/Client's Rights Policy

Each Proposer shall have a written policy stating that the service will comply with client's rights requirements as specified in DHS 94, Wisconsin Administrative Code.

4.5 Security of Electronic Data – Privacy and Confidentiality

Specify the procedures that will be implemented to ensure privacy and confidentiality, including by whom and how data will be collected, procedures for administration of data collection instruments, where data will be stored, who will/will not have access to information, and how the identity of participants will be safeguarded (e.g., through the use of a coding system on data records; limiting access to records; storing identifiers separately from data).

Grant recipients must maintain the confidentiality of alcohol and other drug abuse client records in accordance with the provisions of Title 42 of the Code of Federal Regulations, Part 2 (42 CFR, Part 2), Health Insurance Portability and Accountability Act (HIPAA) 45 CFR Parts 160 and 164, Wis. Stat. 51.30, and DHS 92.

Record Retention. Grantees must store and safeguard all Crisis records against loss, destruction, or unauthorized use consistent with s. 51.30, Wis. Stats., which deals with confidentiality of treatment records. All Crisis records must be kept for at least a seven-year period. In the event that the contract is not renewed, records must continue to be retained in accordance with above regulations.

Grantees must purchase and maintain encryption software using at least 256 bit encryption software for all electronic information on any storage device that contains personally identifiable information related to a person served through Crisis Intervention. Additionally, grantees must use encryption software to send any electronic information containing personally identifiable information related to a person served through Crisis Intervention.

4.6 Affirmative Action Plan and Civil Rights Compliance

4.6.1 Affirmative Action Plan.

Grant recipients who are awarded contracts of fifty thousand dollars ($50,000) or more shall have included in their contracts the following clause: "A written affirmative action plan is required as a condition for the successful performance of the contract. Excluded from this requirement are grant recipients whose annual workforce amounts to less than fifty (50) employees. The affirmative action plan shall be submitted to the Contract Administrator within fifteen (15) working days following the award of the contract."

4.6.2 Civil Rights Plan

Grant recipients who are awarded contracts of fifty thousand dollars ($50,000) or more with an annual work force of twenty-five (25) employees or more shall complete and keep on file a Civil Rights compliance plan compliant with the most recent DHS Civil Rights Compliance Requirement publication. All Grantees must submit a Civil Rights Compliance Letter of Assurance to the Office of Affirmative Action and Civil Rights Compliance within fifteen (15) working days of the award date.

4.7 Tobacco Smoke Free Environment

Public Law 103-227, also known as the Pro-Children Act of 2001, prohibits tobacco smoke in any portion of a facility owned, leased, or contracted for by an entity that receives federal funds, either directly or through the State, for the purpose of providing services to children under the age of 18.

5.0 PROPOSER INFORMATION SECTION

Section 5.0 contains information for Proposers regarding the responsibilities, deliverables and outcomes the contractor is responsible for providing as part of this project.

5.1 Goals, Objectives and Performance Expectations

The Proposer should have clear, achievable goals and objectives for this project. The Proposer's goals and objectives should be consistent with DMHSAS' goals for this grant stated in Section 1.1. Effectiveness of this initiative will be tracked through at least three data sources: (1) encounter data reported into the Program Participant Survey (PPS); (2) an electronically submitted Excel spreadsheet; and (3) summary data and locally specific, grantee-specified outcomes reported into the Performance Monitoring report (as specified in Appendix C). There are five (5) goals and twelve (10) objectives of this initiative:

5.1.1 Goal I: Extend Service Outreach and Array.

1. **Objective.** Improved identification of youth with apparent SED as evidenced by number of youth screened through Crisis being increased by a minimum of 15 percent over the prior year, following establishment of a first-year baseline (As reported into PPS or Excel spreadsheet electronically submitted).
2. **Objective.** Increased frequency of youth Crisis diversions (defined in Appendix D) from behavioral health hospitalization as evidenced by an annual 10 percent increase following the establishment of a one-year baseline (as reported into PPS).
3. **Objective.** Reduced annual frequency of psychiatric hospitalization for youth as evidenced by a 10 percent decrease following the establishment of a one-year baseline (as reported into PPS).
4. **Objective**. Maximize the number of residential stabilization resources for youth as evidenced by identified partnership with or operation of a minimum of one additional stabilization bed following the first year baseline and then planning for meeting the need for stabilization beds (as reported into electronic data reporting system to be provided to grantees).
5. **Objective.** Assure continuity of all outpatient referrals for all youth diverted from hospitalization, hospitalized, or referred to an outpatient provider as evidenced by Crisis providing a minimum of one follow-up interim contact in a minimum of 85 percent of cases until it is verified that the client is admitted to an outpatient agency. By year four ensure universal follow-up contacts to a minimum of 98 percent (as reported into PPS and electronic data reporting system).

5.1.2 Goal II: Improve Linkages to Partners.

6. **Objective.** In addition to required MOU with CST (if it exists in the Crisis service area), maximize the number of partnerships and collaborations between Crisis and agencies serving youth as evidenced by supporting MOUs, meeting minutes, or other documented evidence (as reported on a standardized Excel spreadsheet log to be submitted electronically). Other partnerships to be sought include schools, Child Protective Services (CPS), Juvenile Justice, homeless and runaway systems, Comprehensive Community Services (CCS in DHS 36), Children's Long-Term Support (CLTS) Waiver, Community Support Programs (CSP in DHS 63), Developmental Disability (DD), Outpatient Clinics (DHS 35), alcohol and drug providers, hospitals, and law enforcement agencies, among others. For potential partnerships where barriers appear to exist, analyze challenges and design strategies to forge better alignments.

5.1.3 Goal III: Improve Suicide Prevention.

7. **Objective.** Universal suicide screening of Crisis contacts with at minimum of 90 percent (increasing to 100 percent by the fourth year) of Crisis contacts having documented evidence of screening (tracked and reported into PPS).
8. **Objective.** For all individuals presenting to Crisis with suicidal ideation, ensure universal follow-up outreach contacts within two calendar days by Crisis as evidenced by a minimum of 90 percent (increasing to 100 percent by grant's end) of all individuals with suicidal risk (as reported into PPS).

5.1.4 Goal IV: Enhance Person-Centered, Strengths-Based, Trauma Informed Approaches

9. **Objective.** Assure person-centered, strengths-focused planning on the part of youth and their families as evidenced by an annual minimum of 80 percent of clients reporting that they are satisfied with Crisis services measured by the program's client satisfaction measure (as reported into the Performance Monitoring report, following Department approval of the protocol for and specific use of a client satisfaction measure).

5.1.5 Goal V: Enhance Cultural Competency and Linguistic Appropriateness and Expansion of Breadth of Services

10. **Objective.** Assure continuous development of cultural and linguistic competence by developing and implementing a documented work plan as evidenced by reporting into the standardized DMHSAS Performance Monitoring form (see Appendix C).

5.2 Program Design and Methodology

DMHSAS is soliciting Proposals that demonstrates a high quality, innovative and cost effective approach for the provision of collaborative youth crisis intervention services that meet the goals and objectives above. Proposers are encouraged to design initiatives to meet the unique needs of their service area that accomplish this and meet the minimum requirements above.

5.3 Work Plan

A work plan is an organizational tool that identifies significant goals, objectives, activities, measures, timelines, and responsible parties for a project. Each Proposer, through their work plan and budget detail, should provide sufficient justification for proposed staffing and other resources funded through the project.

DHS is looking for a Proposer that has the capacity to implement the expectations of the RFP and the Proposer's objectives and work plan. The Proposer is expected to have thoughtful plans for assuring adequate staff or contractor resources in a timely manner to complete objectives according to the Proposers work plan.

5.4 Organizational Experience and Capacity

Proposers are required to describe their organizational experience and capacity to accomplish the stated goals and objectives. Proposers shall have demonstrated capacity to promote DHS 34, Subchapter III rule compliance, policies, and practices. Moreover, it is expected that Proposers will have unequivocal experience in developing or delivering evidence-based and best practices. Organizations should have substantial background working in the Wisconsin Medicaid[41] environment with solid skills in the documentation and billing requirements. Essential to this project, Proposers must be able to develop, facilitate, or collaborate with other agencies to develop youth stabilization resources, (including residential) toward increasing diversion efforts. Understanding of provisions for minors within Wisconsin Chapter 51, and related code (DHS 92[42] and DHS 94[43]) are key, along with provisions within Wisconsin Chapter 48[44] (Children's Code) and familiarity with Wisconsin Chapter 938[45] (Juvenile Justice Code) and Wisconsin Department of Public Instruction[46] (DPI) requirements.

5.5 Reporting, Performance Measurement & Quality Improvement

5.5.1 Contractual Accountability.

Project contractors will be responsible for maintaining communication with the State Contract Administrator, Brad Munger, providing periodic updates, briefing on challenges or barriers, trying to identify resources, etc. Moreover, contractors are required to submit biannual (twice annual reports) to the Contract Administrator on the progress being made on the project.

5.5.2 Project Evaluation:

Projects will be evaluated against the criteria laid out in the Goals and Objectives of this RFP and the individual project goals established and reported on using DMHSAS Form F-20389 in

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[41] Wisconsin ForwardHealth (Medicaid) Webpage: https://www.forwardhealth.wi.gov/WIPortal/Default.aspx

[42] Wisconsin DHS 92, Confidentiality of Treatment Records: http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/92.pdf

[43] Wisconsin DHS 94, Patient Rights and Resolution of Patient Grievances: http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/94.pdf

[44] Wisconsin Chapter 48, Children's Code: http://docs.legis.wisconsin.gov/statutes/statutes/48.pdf

[45] Wisconsin Chapter 938, Juvenile Justice Code: http://docs.legis.wisconsin.gov/statutes/statutes/938.pdf

[46] Wisconsin Department of Public Instruction: http://dpi.wi.gov/

Appendix C. Proposers are to frame their objectives as "SMART" deliverables: Specific, Measurable, Attainable, Relevant, and Time-Bond.

5.5.3 Project Performance Measures

Proposers objectives may evolve through the course of the contract as objectives are met or amended but reporting on the current RFP Goals and Objectives will remain throughout the project. Any amendments to contractor objectives must be discussed with and approved by the State Contract Administrator.

5.5.4 Data Quality Reporting Standards

Contractors will report data to the State Contract Administrator through contemporary updates to PPS, additional electronic reporting on objectives not measured by PPS, and the unique project objectives as formulated on the DMSAS Form F-20389.

5.5.5 Implementing a Quality Improvement Process

Proposers are to describe in their response to this RFP the areas where continuous quality improvement processes will be employed (e.g., PIE, NIATx, or related strategies) and tie them to the deliverable SMART objectives in DMHSAS Form F-20389.

6 TECHNICAL RESPONSE SECTION

Listed below are the technical proposal response requirements. The section(s) referenced within the response requirement provide detail concerning the required and/or desired objectives, work requirements, and standards to meet the needs of this program. This detail represents the minimum level of service requirements and objectives sought in this procurement. Many of the sections in this RFP are interrelated and may contain overlapping information. Proposers should incorporate the goals, objectives, work requirements, and standards stated throughout this RFP into their proposal.

Proposers must respond to these elements with a descriptive narrative (appropriately labeled in accordance with the numbering scheme below) that includes methodology to the level of detail deemed appropriate by the Proposer.

6.1 Goals, Objectives and Performance Expectations

Proposers must describe goals, objectives and performance expectations for each year of the grant, and fulfill the requirements described in Section 1.1 and 5.1.

Proposals will be evaluated based on scope, feasibility, reasonableness, and measurability of the deliverable outcomes designed to support the goals of this RFP. Domains for system and

service improvements are identified and described within the rubrics below, ranging from *extending the service outreach and array* to expanding the *breadth of crisis delivery*. It is not required that proposals address all domains or areas but rather that they build on a service area's strengths and address identified needs in the service of meeting the overall objectives of this RFP. As such, Proposers may want to evaluate how well their service area currently satisfies each domain. Beneath each domain there are some examples of ways to expand the effectiveness of Crisis programs, through changes within the Crisis system or by networking or partnering with other collaborators. Examples under each rubric are neither exhaustive nor required; rather they are sample directions for expanding or improving services to youth with SED. References or appendices provide more guidance or give examples. Collaborations and synergies will be key to the successful achievement of proposal goals.

6.2 Program Design and Methodology

Proposers describe and define a viable model for the project that addresses the specifications noted in this RFP. Proposers should address the following information in the response to this section:

6.2.1 Extending Service Outreach and Array. It has been the objective of the previous funding cycles to achieve statewide coverage for Crisis Intervention services. While there has been a marked expansion, there remain areas, which are not currently covered under a DHS 34, Subchapter III Crisis Intervention entity. At its most basic level, this means having 24-hour phone services every day, 8 hours of mobile services every day, and walk-in services five days per week. The Crisis rule requires that phones be answered by DHS 34 qualified, trained, and supervised staff, 24 hours a day, 365 days per year. Phone calls must not require routing, transfer, or be taken by an answering machine or voicemail. Mobile services are to be provided in accordance with DHS 34 and function as other first responders, being able to provide an expedited community response a minimum of 8 hours per day. Ideally, mobile services should be available full-time to the extent that resources allow. Just as fires can occur at any time requiring an immediate response of a fire department, mental health crisis can occur at any time and should be met with a speedy response. It is anticipated that grantees will develop strategies for extending DHS 34, Subchapter III (i.e., phone, walk-in, mobile) services to counties not currently certified and billing to Medicaid. It is sometimes overlooked that all persons under a Chapter 51 commitment, or settlement agreement or stipulation *de facto* meet the criteria for being at high risk for having a mental health crisis, thus warranting development of a Crisis Plan in collaboration with other outpatient treatment service providers. While general expansion of services can have a robust positive impact on youth, there are a variety of other

ways to expand youth-specific services, not the least of which is strategies to utilize social media.

- Strategies for more effective use of telehealth resources; plans for telehealth certification.[47,48]
- Plans for expanding DHS 34 mobile coverage beyond the minimum requirements of the administrative rule with a model and strategy to objectively measure increased mobile services with on-site service provision (home, school, work, youth activity center, etc.). Response times of police and fire departments are routinely monitored objectively; a plan could be made to measure Crisis mobile response times.
- Plan for creatively expanding residential diversion opportunities, especially for youth (e.g., dual-licensed foster/Adult Family Homes).
- Plan for ensuring that all individuals under a Chapter 51 commitment or settlement agreement/stipulation have regular Crisis follow-up according to an individualized Crisis Plan that is collaborative with outpatient treatment resources.
- Strategies for helping youth and families obtain needed resources such as income and health insurance in order to access treatment and recovery services.
- Plan for developing a protocol for screening and identifying substance use disorder, related risks, co-occurring disorders amongst Crisis clients. SBIRT (Screening, Brief Intervention and Referral to Treatment) is a reimbursable evidence-based practice under Crisis Intervention.[49,50, 51]

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[47] Numbered DDES Memo 2004-14 on Telehealth: http://www.dhs.wisconsin.gov/dsl_info/NumberedMemos/DDES/CY_2004/NMemo2004-14-DDES.htm; and Forward Health Online Handbook: https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Telemedicine&adv=Y

[48] Request for Approval to use Telehealth (form F-62589): http://search.wi.gov/cs.html?url=http%3A//www.dhs.wisconsin.gov/forms1/F6/F62589.doc&charset=iso-8859-1&qt=url%3Adhs.wisconsin.gov+%7C%7C+telehealth&col=&n=1&la=en

[49] Forward Health Memo 2009-96 on SBIRT: https://www.forwardhealth.wi.gov/kw/pdf/2009-96.pdf

- Plan for actively engaging with partner programs towards supporting seamless transition of SED youth to adult systems of care.
- Involving peers with lived-world experience on the development or revision of the Coordinated Emergency Services Mental Health Services Plan, Crisis Intervention Policies, and/or the provision of services.[52]
- Collaboration with law enforcement agencies for expansion of Crisis Intervention Team Training (CIT), or the *Memphis Model,*[53] with focus on youth. CIT is already being implemented in parts of Wisconsin.[54] Legislation was recently enacted provide additional funding for CIT in Wisconsin.[55]
- Plan for providing mobile crisis services to rural areas.[56]

6.2.2 Linking to Partners. Success of Crisis programs rests on community awareness of the resources of Crisis Intervention and how effectively Crisis programs connect to a wide variety of community partners (the most noticeable being law enforcement and psychiatric inpatient services). New challenges impact the ability to obtain Medicaid reimbursement for youth under an emergency detention if the reasons for the detention didn't specifically involve the health or safety of the youth.[57] Notably if the youth is presenting a danger to others but is not imminently dangerous to him- or her-self, then he or she can be emergently detained under

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[50] Treatment Intervention Protocol (TIP-50): http://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA09-4381

[51] 1 in 11 Past Year Illicit Drug Users Had Serious Thoughts of Suicide: http://www.samhsa.gov/data/spotlight/spot129-suicide-thoughts-drug-use-2014.pdf

[52] Advancing Peer Support in Suicide Prevention: http://www.sprc.org/directorsblog/advancing-peer-support-suicide-prevention

[54] National Alliance on Mental Illness (NAMI) Fox Valley and CIT: http://www.namifoxvalley.org/citlaw.html

[55] 2013 Wisconsin Act 126: https://docs.legis.wisconsin.gov/2013/related/acts/126

[56] 2013 Wisconsin Act 132: https://docs.legis.wisconsin.gov/2013/related/acts/132.pdf

[57] DMHSAS Informational Memo: 2014-02: http://www.dhs.wisconsin.gov/dsl_info/InfoMemos/DMHSAS/CY2014/2014-02InfoMemo.pdf

Wisconsin Chapter 51.15, however, reimbursement from the Medical Assistance program cannot be sought.

Yet there are hosts of other partners where synergies can be developed and strengthened in the service of improved outcomes for the consumer. Many Crisis programs collaborate around developing Crisis Plans or sometimes what might be thought of as *anticipatory crisis plans* for participants in Community Support Programs (CSPs). Other areas of partnership and collaboration which are already universal are especially relevant to the goals of this funding are schools and school districts, child welfare and Child Protective Service (CPS), and Juvenile Justice. Expanding areas for partnership include, Coordinated Service Teams (CSTs), Comprehensive Community Services (CCS), DHS 35 outpatient mental health clinics, to name a few.

Opportunities and challenges for partnerships present themselves in new developments within some of these programs. New availability of funding for *all* counties to pursue or revitalize CST programs[58] is being made available. Similarly, within CCS there are new opportunities for funding for the non-federal share of Federal Medical Assistance Percentages (FMAP) for programs serving a regional area.[59, 60] Within DHS 35 outpatient mental health clinics there is a new opportunity for providers to be reimbursed for in-home services for youth (excluding travel).[61] Moreover new technological horizons pose more opportunities and challenges for connection with youth—social media websites, text message or short message service (SMS), email, videoconferencing, etc. (e.g., Facebook, Tumblr, Instagram, SnapChat, Twitter, etc.). These new technologies also offer potential benefits for connecting to other cultural minorities, including the Deaf, opening an opportunity for broader service coverage to the culturally prepared and trained agency.

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[58] DMHSAS CST Action Memo 2013-07: http://www.dhs.wisconsin.gov/mh_bcmh/CST/ActionMemo201307.pdf

[59] DMHSAS CCS Action Memo 2013-06: http://www.dhs.wisconsin.gov/dsl_info/NumberedMemos/DMHSAS/CY2013/Docs/CCSMemoIntenttoProvide1113.pdf

[60] DMHSAS CCS Information Memo 2014-01: http://www.dhs.wisconsin.gov/dsl_info/InfoMemos/DMHSAS/CY2014/2014-01InfoMemo.pdf

[61] See the DHS Forward Health Update for December 2013: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/Updates/Index.htm.spage

- Required within all proposals is a plan for assuring close linkages and specific MOUs to Coordinated Services Teams (CST),[62,63] if CST exists in the service area. CSTs are a group of individuals, including family members, service providers, and informal resource persons, who work together to respond to service needs of a child who is involved in two or more systems of care and his or her family. CSTs are required to have plans to respond to crisis situations.[64]

- Plan for assuring improved linkages to DHS 35[65] outpatient clinics, especially for children. Include plans for active outreach to outpatient clinics to help explain Crisis Intervention services and the delineation of clinic responsibilities, Crisis responsibilities, and the nature of effective collaboration.

- Strategy for developing alliances and collaborations with schools including specific MOUs.[66]

- Connecting to the Safe Schools/Healthy Students Initiative.[67]

- Strategy for developing alliances for collaboration with child welfare, Children's Long-Term Support (CLTS),[68] juvenile justice, and runaway[69] and homeless[70,71] services.

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[62] Wisconsin Statutes 46.56: http://docs.legis.wi.gov/statutes/statutes/46/56/1/op

[63] Coordinated Service Team (CST): http://www.dhs.wisconsin.gov/mh_bcmh/cstisp.htm

[64] "Plans for responding to possible crisis situations that may occur with the child and his or her family." 46.56(8)(h)8.

[65] Wisconsin Outpatient Mental Health Clinic Standards: http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/35.pdf

[66] Dept. of Public Instruction: Youth Suicide Prevention: http://sspw.dpi.wi.gov/sspw_suicideprev

[67] SAMHSA Safe Schools/Healthy Students: http://www.sshs.samhsa.gov/initiative/default.aspx

[68]Children's Long-Terms Support Waivers (CLTS): http://www.dhs.wisconsin.gov/children/clts/

[69] Wisconsin Association of Homeless and Runaway Services: http://wahrs.org/youthPrograms.html; DOJ Missing Persons Runaway Programs: http://www.missingpersons.doj.wi.gov/content/WIRunawayProg.pdf

[70] Wisconsin Legislative Reference Bureau Report on Youth Homelessness: http://legis.wisconsin.gov/lrb/pubs/ttp/ttp-04-2013.pdf

Wisconsin Statutes Chapter 51 requires the needs of homeless youth be taken into account by county Departments of Community Programs. The plan shall state how the needs of *homeless* persons and adults with serious and persistent mental illness, children with serious emotional disturbances and minorities will be met by the county department of community programs.[72]

- Eventual development of MOUs between the Crisis Intervention program and other youth agencies.
- Plan for expanding linkage and coordination services, including for community stabilization, post-hospitalization, post-residential stabilization, emergency detention, individuals committed under Chapter 51.
- Strategies for tracking and assuring linkage and coordination from first contact through follow-up community service provision
- Strategies for linking individuals to resources to obtain health insurance coverage (e.g., disability referrals, BadgerCare, Insurance Exchange, Medicaid deductible, etc.)
- Plan for participation in emergency and disaster preparedness[73] with relevant MOUs (e.g., *Continuity of Operations Plan* (COOP) and *Functional Assessment Service Team* (FAST)[74] Training) or SAMHSA's Technical Assistance Report (TAP) 34: Disaster Planning Handbook for Behavioral Health Treatment Programs.[75]

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[71] Wisconsin Division of Housing-Bureau of Supportive Housing: http://doa.wi.gov/Divisions/Housing/Bureau-of-Supportive-Housing

[72] Wisconsin Statutes § 51.42(3)(ar)5: http://docs.legis.wisconsin.gov/statutes/statutes/51.pdf

[73] Wisconsin Emergency Management webpage: http://emergencymanagement.wi.gov/

[74] Functional Assessment Service Team (FAST) Training: http://emergencymanagement.wi.gov/resources/fast.asp

[75] SAMHSA's Technical Assistance Report 34 on Disaster Planning Handbook for Behavioral Health Programs: http://store.samhsa.gov/product/TAP-34-Disaster-Planning-Handbook-for-Behavioral-Health-Treatment-Programs/BackInStock/SMA13-4779

- Developing strategies to engage social media toward helping connect with youth.[76]
- Plan for coordinating with texting resources[77] (See the Center for Suicide Awareness, Texting Hopeline[78])
- Plans for collaborating with County Corporation Counsel to further mutual appreciation of the impact of emergency detention, commitment, stipulations or settlement agreements, and the mandate with treating in the least restrictive setting. Identify the impacts on the person being served and their family, the county, crisis program, etc. What is the person impact, clinical impact, liability, cost, etc.?

6.2.3 Suicide Prevention. Of course, a key function of Crisis Intervention revolves around proper identification of, assessment of, and assistance to persons in managing a suicidal crisis; not only in the acute phase but in the situations leading up to such a crisis. As part of this project DHS tracks suicides[79,80] statewide as well as in the areas served through this project. Moreover, Crisis Intervention has a central function in the longer-term effort to help individuals regain hope and efficacy in their lives following a suicidal crisis toward mitigating future crisis and periods of acute suicidality. Since the original Crisis rule was published there has been considerable literature published on meaningful, evidence-based, and best-practice approaches to suicide prevention.[81,82,83] Perfect Depression Care initiatives in Detroit have shown

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[76] Responding to a Cry for Help: Best Practices for Online Technologies: http://www.sprc.org/bpr/section-II/responding-cry-help-best-practices-online-technologies

[77] Text Hopeline is a new initiative in Wisconsin that will eventually become a statewide resource: http://suicidepreventionandresourcecenter.org/volunteer/hopeline/

[78] Center for Suicide Awareness, Texting Hopeline: http://suicidepreventionandresourcecenter.org/volunteer/hopeline/

[79] DHS Wisconsin Interpretive Statistics on Health (WISH Query: http://www.dhs.wisconsin.gov/wish/measures/mortality/long_form_detail.html

[80] Burden of Suicide Report: http://www.mcw.edu/injuryresearchcenter/Burden-Of-Suicide-In-Wisconsin-Report.htm

[81] Suicide Assessment Website: http://www.suicideassessment.com/

[82] Suicide Prevention Resource Center: www.sprc.org

[83] American Association of Suicidology: www.suicidology.org

remarkable success.[84] Here in Wisconsin, efforts in recent years with support from the Mental Health Block Grant and Garret Lee Smith grants, there is now a central clearinghouse for suicide prevention efforts at Prevent Suicide Wisconsin (PSW),[85] identifying suicide prevention resources and local suicide prevention coalitions. Means restriction efforts have shown to be effective.[86] New strategies have evolved to focus on the high-risk demographic of middle-aged males in Man Therapy,[87] which is being deployed in Wisconsin. Broad universal prevention strategies have shown to be effective, such as Question-Persuade-Refer (QPR).[88] The *Columbia Suicide Severity Rating Scale* (C-SSRS),[89] purports to minimize false positives and overreaction upon initial screening, and has been used widely around the country. There are versions for youth and for adults. Indeed, it is being used universally in some states such as New York, Tennessee, Utah, and here in Wisconsin through the Department of Corrections. Certain counties have also adopted the C-SSRS universally (e.g., Lapeer County in Michigan). A new electronic version is now available for self-assessments as well: eC-SSRS. It fits well into the standard of practice of universal screening for suicide risk.

Suicide prevention is a central role of Crisis Intervention programs. Unfortunately, it is a too common error for interventionists and clinicians to shortchange the assessment of intoxicated persons; considering the fact that alcohol use confers a six to 10 times risk of suicide, people who are intoxicated need just as thorough of an assessment as those without an alcohol use disorder. Intervention strategies can be developed to help make the person safer the next time they are intoxicated.

There are a multitude of ways that programs can enhance their effectiveness toward better identification and management of the person at risk for suicide, some of which are described

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[84] Henry Ford Health Care—Perfect Depression: http://www.henryford.com/body.cfm?id=46335&action=detail&ref=1104 and http://www.dhs.wisconsin.gov/mh_bcmh/confandtraining/PerfectDepressionCareTwoSlidesPerPage.pdf

[85] www.preventsuicidewi.org

[86] Harvard University of Public Health—Means Matter: http://www.hsph.harvard.edu/means-matter/means-matter/

[87] Man Therapy: http://mantherapy.org/

[88] Question, Persuade, Refer: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=299

[89] C-SSRS: http://www.cssrs.columbia.edu/

below. Developing plans to achieve greater competence in suicide prevention and integrating those into training, policy, procedure is what will be required. Programs need to be able to comfortably engage individuals, properly complete a screening and assessment of suicide risk, be well-prepared to discern level of risk, and be able to design strategies to help the person at risk of suicide manage their situation, including sound safety planning with a six-month Crisis Plan or one-month Response Plan.

- Plan for developing policies and procedures assuring that *all* contacts are asked about suicidal ideation and means (see Appendix A)
- Plan for developing active means restriction protocols for suicide prevention.[90]
- Plan for incorporating guidance from the National Strategy for Suicide Prevention into practices of the Crisis Intervention Program.[91,92]
- Plan for adoption of best practice standards for suicide crisis lines.[93]
- Plans to substantially enhance and develop staff skills in clinical interviewing, assessment,[94] management, and documentation of individuals at risk of suicide.
- Strategies for reducing unnecessary emergency department (ED) contacts and streamlining medical clearance processes.
- Strategies to incorporate best practices and evidence-based practices into the Crisis Intervention program.[95]

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[90] Emergency Department Means Restriction Education (an evidence-based practice): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=15

[91] National Strategy Suicide Prevention: http://actionallianceforsuicideprevention.org/NSSP

[92]2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

[93] Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline: http://www.sprc.org/bpr/section-II/standards-assessment-suicide-risk-among-callers-national-suicide-prevention-lifeline

[94] Training Institute for Suicide Assessment and Clinical Interviewing: http://www.suicideassessment.com/web/top-level/case.html

- Plans to develop crisis service delivery beyond the scope of DHS 34, incorporating the accreditation standards of the American Association Suicidology.[96]
- Plan to develop post-vention protocols in the event of a community suicide.[97]
- Training plans for Crisis staff in state-of-the-art core competencies and curricula, for assessment and management of the suicidal individual.[98]
- Certification of individual crisis staff in suicide management through the American Association of Sucidology.[99]
- Strategies for reciprocal connections to suicide prevention coalitions.[100]
- Systematic communicative and compassionate follow-up following a suicidal event.[101,102,103]

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[95] Suicide Prevention Resource Center, Best Practices Registry: http://www.sprc.org/bpr

[96] American Association of Suicidology (AAS) Crisis Center Accreditation standards for example, regardless if accreditation is purchased: http://www.suicidology.org/c/document_library/get_file?folderId=250&name=DLFE-875.pdf

[97] After a Suicide: A Toolkit for Schools: http://www.sprc.org/webform/after-suicide-toolkit-schools

[98] Recognizing and Responding to Suicide Risk (RRSR): http://www.suicidology.org/training-accreditation/recognizing-responding-suicide-risk; Assessment and Management of Suicide Risk: http://www.sprc.org/training-institute/amsr; ASSIST: http://www.nosp.ie/html/training.html; SAFE-T: http://www.sprc.org/bpr/section-III/suicide-assessment-five-step-evaluation-and-triage-safe-t; and others: http://www.sprc.org/training-institute.

[99] AAS Provider Certification: http://www.suicidology.org/c/document_library/get_file?folderId=251&name=DLFE-515.pdf.

[100] Prevent Suicide Wisconsin: www.preventsuicidewi.org.

[101] Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. http://www.suicidology.org/c/document_library/get_file?folderId=236&name=DLFE-331.pdf

[102] Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries: http://www.who.int/bulletin/volumes/86/9/07-046995.pdf

- Utilization of online suicide prevention training resources.[104]
- Ensuring follow-up: connections before discharge to meet the person, reminder letters or phone calls, etc. to ensure appropriate linkage and follow-up.

6.2.4 Person-Centered, Strengths-Based, Trauma-Informed Approaches. Many agencies purport to be consumer-centric and to abide strengths-based, person-centered, culturally appropriate, and trauma informed practice. Nevertheless, in the busy day-to-day practice, clinics can often fall short of these critical practices. Programs tend to assume they are abiding these contemporary principles but upon reflection, it is almost certain that examples will become evident where practices were less than attentive to the person's wealth of assets; or neglected their traumatic experiences, perhaps even re-traumatizing them; or simply did not involve the individual and significant others in planning. In what ways can our practices become more person-focused? Plans for being more mindful of and enriching a culture of trauma informed,[105] person-centered planning,[106] tapping into strengths[107, 108, 109, 110] can be developed in our Crisis teams. It can be assessed and monitored through interactions with consumers and their families and be implied in the clinical documents we prepare.

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[103]A Randomized Controlled Trial of Postcrisis Suicide Prevention: http://journals.psychiatryonline.org/data/Journals/PSS/3569/828.pdf

[104] SPRC Suicide Prevention Online Training: http://training.sprc.org/

[105] DHS: Trauma Informed Care website: http://www.dhs.wisconsin.gov/tic/

[106] Cornell University Person-Centered Planning Website: http://ilr-edi-r1.ilr.cornell.edu/PCP/

[107] The Importance of Taking a Strength-Based Perspective: http://www.crisisprevention.com/Resources/Article-Library/Nonviolent-Crisis-Intervention-Training-Articles/The-Importance-of-Taking-a-Strength-Based-Perspect.

[108] From Coercive to Strength-Based Intervention: Responding to the Needs of Children in Pain: http://nospank.net/brendtro.pdf

[109] Rapp, Charles and R. Goscha. The Strengths Model: A Recovery-Oriented Approach to Mental Health Services (3rd Ed.). Oxford University Press: 2012

[110] Greene, Gilbert, et. Al. How to Work With Clients' Strengths in Crisis Intervention: A solution-Focused Approach in Crisis Intervention Handbook: Assessment, Treatment and Research (3rd Ed.) Albert R. Roberts. Oxford University Press: 2005.

- Plan to develop person-centered, strengths-based crisis planning with measured outcomes.
- Plan for assuring that services are abiding principles of a Trauma-Informed Care (TIC) system.
- Strategy for training staff to practice these approaches.

6.2.5 Youth Competency, Cultural Competency and Linguistic Appropriateness. Competency in the area of youth culture and development are foundational to effective service delivery in a crisis system serving those with severe emotional disturbance (SED). Awareness of and ability to identify the strengths and needs of youth overlap with other cultural and linguistic considerations (e.g., a youth from a military family as compared to a deaf child with hearing parents; or a transition-aged American Indian youth as opposed to a gay 17 year old). Crisis programs must be properly prepared to meet the unique needs of their service areas, which would be articulated in the Coordinated Emergency Mental Health Services Plan. Touch points for youth obviously include schools, child welfare agencies, juvenile justice agencies, not to mention other mental health and substance use providers, from inpatient to residential to outpatient. CST, CCS, increasingly CSPs, CLTS and DD agencies all have roles to play as well as children grow and develop and ultimately transition to adulthood. Growing diversity challenge and call upon Crisis Programs to be more skilled at working with a variety of cultural groups and people with different primary languages.

- Strategies for engaging with unique communication vehicles of youth and social media.
- Strategies and preparation for responding to the unique developmental and cultural aspects of adolescents and transition-aged youth.[111]
- Plans for training in cultural competence.
- Strategies for identifying the prominent needs of the service delivery area, both in terms of linguistic appropriateness and cultural competence (e.g., American Indian,[112,113]

[111] Project O'YEAH in Milwaukee: http://wraparoundmke.com/programs/92-2/ and http://files.www.cmhnetwork.org/share-your-voice/save-the-healthy-transitions-initiative/what-does-the-data-tell-us-about-the-healthy-transitions-initiative/Project_oyeah_model.pdf

[112] Model Adolescent Suicide Prevention Program (MASPP): http://nrepp.samhsa.gov/ViewIntervention.aspx?id=251

Hispanic,[114] African American,[115] Asian,[116] Deaf or Hard of Hearing,[117] LGBT,[118] Service Members, Veterans and their Families [SMVF],[119] etc.) and a timeline for incorporating modifications in practice to better serve those groups in the Coordinated Emergency Mental Health Services Plan, DHS 34.22(1) and the local plan for the County Department of Community Services, 51.42(3) ar 5.120

- Strategies for hiring bilingual staff.
- Plan to train a higher level of competence in Deaf culture.

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[113] Suicide Prevention Strategies for American Indian/Alaska Native Youth: http://actionallianceforsuicideprevention.org/system/files/LaFromboise%20SAMHSA%20Chicago%20Presentation%202013b.pptx

[114] Suicide Prevention Resource Center Fact Sheet on Hispanics: http://www.sprc.org/sites/sprc.org/files/library/Hispanics%20Sheet%20Aug%2028%202013%20Final.pdf

[115] Suicide Prevention Resource Center on Blacks: http://www.sprc.org/sites/sprc.org/files/library/Blacks%20Sheet%20August%2028%202013%20Final.pdf

[116] Suicide Prevention Resource Center on Asians: http://www.sprc.org/sites/sprc.org/files/library/API%20Sheet%20August%2028%202013%20Final.pdf

[117] Suicide in Deaf Populations: A Literature Review: http://www.annals-general-psychiatry.com/content/6/1/26

[118] Helping LGBT Youth Find a Brighter Future: http://actionallianceforsuicideprevention.org/system/files/Abbe%20Land%20presentation.zip_.pdf

[119] Operation SAVE: http://www.sprc.org/bpr/section-III/operation-save-va-suicide-prevention-gatekeeper-training

[120] Prepare a local plan which includes an inventory of all existing resources, identifies needed new resources and services and contains a plan for meeting the needs of the mentally ill, developmentally disabled, alcoholic, drug abusers and those with other psychiatric disabilities for citizens residing within the jurisdiction of the county department of community programs and for persons in need of emergency services found within the jurisdiction of the county department of community programs. The plan shall also include the establishment of long−range goals and intermediate−range plans, detailing priorities and estimated costs and providing for coordination of local services and continuity of care. *The plan shall state how the needs of homeless persons and adults with serious and persistent mental illness, children with serious emotional disturbances and minorities will be met by the county department of community programs. The county department of community programs shall submit the plan to the department for review under sub. (7) (a) 9. and s. 51.02 (1) (f) in accordance with the schedule and deadlines established under sub. (7) (a) 9.* [emphasis added]

- Strategies for the involvement of youth in service delivery planning and a timeline for incorporating those changes into the Coordinated Emergency Mental Health Services Plan, DHS 34.22(1), and the local plan for the Department of Community Services, 51.42(3) ar 5.

- Plan to offer psychiatric services to youth through recruitment of youth psychiatry, use of telehealth/tele-psychiatry resources, and/or collaboration and linkage of psychiatric resources to pediatricians and family care physicians. Recently enacted legislation is creating a child psychiatry consultation program.[121] Additionally, other efforts are underway to address the child psychiatry shortage.[122]

6.3 Work Plan

The work plan described in the proposal relates directly to the goals listed in Section 1.1, facilitates program accomplishments, and is sequentially reasonable. Activities in the work plan are assigned to specific personnel. The work plan is consistent with the objectives and can be accomplished in stated timeframes and proposed budget. Timeframes for tasks and activities in the work plan are appropriate to ensure that sufficient effort is planned. This response should include, but is not limited to:

- A detailed description of significant tasks, activities and strategies to be used to achieve the goals in a logical progression

- The assignment of responsibility for work plan tasks to specific personnel and the timetable for significant tasks or activities to be started and to be completed

6.4 Organizational Experience and Capacity

Proposers should submit a response that describes their experience, demonstrated abilities, and technical expertise that includes but is not limited to:

- Demonstrated capacity to promote DHS 34, Subchapter III rule compliance, policies, and practices.
- Experience in developing or delivering evidence-based and best practices.
- Substantial background working in the Wisconsin Medicaid environment with solid skills in the documentation and billing requirements.

[121] 2013 Wisconsin Act 127: https://docs.legis.wisconsin.gov/2013/related/acts/127.pdf#page=1

[122] 2013 Wisconsin Act 128: https://docs.legis.wisconsin.gov/2013/related/acts/128.pdf

- Capacity to develop, facilitate, or collaborate with other agencies to develop partnerships and youth stabilization resources, (including residential) toward increasing diversion efforts.
- Understanding of provisions for minors within:
    - Wisconsin Chapter 51
    - DHS 92, Confidentiality of Treatment Records
    - DHS 94, Patient Rights and Resolution of Patient Grievances
    - Wisconsin Chapter 48 (Children's Code)
    - Familiarity with Wisconsin Chapter 938 (Juvenile Justice Code)
    - Wisconsin Department of Public Instruction (DPI)

6.5 Reporting, Performance Measurement & Quality Improvement

Proposers should submit a response that describes their experience, demonstrated abilities, and technical expertise to fulfill the requirements described in Section 5.5. The Proposer has demonstrated to have an efficient system in place to assure quality and improvement for services. The Proposer clearly describes what their current quality assurance and improvement process is and what changes, if any, will be included for the project in order to fulfill the requirements described in Section 5.5. This response should include, but is not limited to:

6.5.1 A detailed description of the Proposer's current quality improvement and assurance processes that assures financial accountability, program quality, and regulatory compliance.

6.5.2 A description of who will be the Proposer's lead in working with DHS on the Project Evaluation, including the name of the responsible individual(s) or organization (s) that will be actively involved in the evaluation.

6.5.3 A discussion of who would be in charge of quality improvement and assurance for this RFP and what role they would play, if any, in this process.

6.5.4 A description, if applicable, of any changes to the current quality assurance, improvement, and monitoring processes that would be needed for the project.

6.5.5 A description of how data will be promptly and accurately reported to the Program Participant System (PPS) and how performance monitoring will occur on individualized using required bi-annual performance report reporting at six-month intervals with the standardized DMHSAS Form F-20389 (Rev. 10/20/13).

7 PROJECT BUDGET

DMHSAS has developed a budget template (Appendix B) to be used for submitting the project budget. Use of this budget template is required. The budget template is an Excel spreadsheet containing three tabs. The first tab summarizes the detailed budget information entered on the second tab of the worksheet. The third and final tab contains the instructions for completing the budget worksheet. Please review the instructions prior to completing the budget template. Please provide sufficient justification in the designated areas of the second tab to enable reviewers to understand both the level of planned expenditures and the need for the funds. The budget template and instructions are included as an appendix to this document.

The proposed budget must be on the budget template and submitted as a Microsoft Excel file. Please save your budget with a file name that identifies your agency.

All budget costs must comply with the DHS Allowable Cost Policy Manual. The Allowable Cost Policy Manual can be found on the DHS web site at:
http://www.dhs.wisconsin.gov/grants/Administration/AllowableCost/ACPM.htm

8 REQUIRED FORMS

The following pages contain the ancillary forms required to be submitted as part of the Proposal packet. Please reference Section 2.2 for information related to the proper order of these forms in the Proposal packet. The budget spreadsheet is required in accordance with Appendix B and the Performance Monitoring Form is required in accordance with Appendix C.

VENDOR INFORMATION

1. PROPOSING COMPANY NAME _____

   FEIN

   Phone ( ) Toll Free Phone ( )

   FAX ( ) E-Mail Address

   Address

   City State Zip + 4

2. Name the person to contact for questions concerning this Proposal.

   Name Title

   Phone ( ) Toll Free Phone ( )

   FAX ( ) E-Mail Address

   Address

   City State Zip + 4

3. Any vendor awarded over $50,000 on this contract must submit affirmative action information to the department. Please name the Personnel / Human Resource and Development or other person responsible for affirmative action in the company to contact about this plan.

   Name Title

   Phone ( ) Toll Free Phone ( )

   FAX ( ) E-Mail Address

   Address

   City State Zip + 4

4. Mailing address to which state purchase orders are mailed and person the department may contact concerning orders and billings.

Name _____ Title _____

Phone ( ) _____ Toll Free Phone ( ) _____

FAX ( ) _____ E-Mail Address _____

Address _____

City _____ State _____ Zip + 4 _____

5. CEO / President Name _____

APPENDIX A: No Harm Contracts and Failure to Assess and Importance of Empathy

Some recent articles appearing in *Suicide and Life-Threatening Behavior* warrant highlighting. The first pertains to the use of No Harm Contracts by Lisa McConnell Lewis. Her contemporary review of the literature again shows—contrary to popular opinion—*no demonstrated efficacy* to their prevention of suicide nor protection from civil liability. She recommends that they no longer be employed and that greater emphasis should be placed upon the development of safety plans (No harm contracts: a review of what we know. *SLTB, 37[1],* 50-57, 2007).

In a subsequent issue of the journal, an elegant study was made into the inquiry into suicide through 14 crisis centers and over 2,600 calls to the 1-800-SUICIDE network. (Mishara *et al. SLBT, 37[3], 291-307, 2007*[123]*).* AAS[124] accreditation standards maintain that all callers should be asked if they are considering suicide; if an affirmative answer is given, a detailed risk assessment should be undertaken. Furthermore, AAS certification standards and Hopeline emergency procedures, indicate that "rescue should be sent when a caller has initiated a suicide attempt and his or her life appears to be in danger." In the case of an attempt in progress the crisis worker should either convince the caller to stop the attempt or send help. In Mishara's study, investigators found that "most helpers do not ask even the most basic question about suicidal ideations." Then, "when callers do indicate that they are considering suicide, the helpers usually do not proceed to ask about means." Even more startling is that, "when callers tell how they are planning to commit suicide, helpers rarely ask if they have the means available or if they are in the process of an attempt" (p. 305).

In a tandem study by the same lead author within the same *SLBT* issue, it was found that crisis centers varied significantly in the extent to which there were positive and negative changes between the beginning and the end of calls. Additionally, positive outcomes[125] were related to crisis workers who exemplified empathy and respect while taking a supportive approach[126] and

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[123] Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? http://www.hopeline.com/pdf/Evaluation%20of%20the%20Hopeline-%20what%20is%20effective.pdf

[124] American Association of Suicidology

[125] Using the CCORS (Crisis Call Outcome Rating Scale) developed by Bonneson and Hartsough (1987).

[126] Including behaviors such as validation of emotions, giving moral support, good contact, reframing, talking about own experience, and offers to call back.

good contact with collaborative problem-solving.[127] Active listening, on the other hand was not significantly related to positive outcomes. Interestingly, more of the variance for positive changes was attributable to supportive attitude and good contact than to collaborative problem solving. So the take-home messages are:

- Always ask about suicide.
- If an affirmative answer is obtained, do a full assessment.
- When asking about suicide, use the IS PATH WARM[128] mnemonic to detect acute warning signs.
- Be unwaveringly empathic and respectful while taking a supportive approach.
- Maintain good contact and rapport.
- Engage the individual in collaborative problem-solving.
- Realize that active listening, itself, is not related to positive outcome.

A variety of resources are available for connecting to the literature of suicide prevention and Crisis Intervention, just a couple of which are below:

- American Association of Suicidology: www.suicidology.org
- Suicide Prevention Resource Center: www.sprc.org
- American Foundation of Suicide Prevention: www.afsp.org
- Training Institute for Suicide Prevention and Clinical Interviewing: http://www.suicideassessment.com/web/top-level/case.html
- Psychology Wiki—Hotline Services: http://psychology.wikia.com/wiki/Hot_line_services

[127] Such as asking fact based questions about the problem, questioning about resources, suggesting ways to solve the problem, questions on precipitating events, proposing a plan of action, and offering referrals.

[128] American Association of Suicidology—IS PATH WARM: http://www.suicidology.org/c/document_library/get_file?folderId=231&name=DLFE-598.pdf

APPENDIX B: Budget Template

An Excel spreadsheet budget template accompanies this RFP.

APPENDIX C: Performance Reporting

Ongoing Program Participant System (PPS)[129] reporting is a required component of this project. Individualized goals for the Proposer's project require bi-annual performance report at six-month intervals with the standardized DMHSAS Form F-20389 (Rev. 10/20/13). DMHSAS Form F-20389 accompanies this RFP.

[129] Program Participation System (PPS): http://www.dhs.wisconsin.gov/pps/

APPENDIX D: Diversion Definition

Diversion occurs when an adult or child who is involved with Crisis Intervention,[130] within 48 hours of the time of the encounter, as a result of Crisis Intervention services is *diverted* to a less intensive[131] setting that is more appropriate to their clinical need instead of being admitted to a behavioral health hospital.[132] This occurs following an original determination that inpatient services were necessary by one of the following:

- The person themself is in crisis and expresses desire to go inpatient.
- The person themself is expressing suicidal ideation or intent.
- One of the following actors determines that the person should be hospitalized due to apparent suicidal intent or behavior, disorganized or psychotic behavior, or threatened or apparent dangerousness to others:
    - Law enforcement officer
    - Correctional officer in a jail or prison
    - Family member or significant other
    - Clinical practitioner (e.g., psychotherapist, psychologist, doctor, nurse, etc.)
    - Residential support staff (Child Care Institution, Residential Care Centers, Group Home, Community Based Residential Facility [CBRF], Foster Home, Adult Family Home, Residential Care
    - School Staff or Teacher
- Or the person presenting to Crisis manifests with unstable thinking, behavior or emotions wherein it is determined that without Crisis Intervention or Crisis Stabilization

[130] Crisis Intervention Involvement is defined as having Crisis contact requiring an open clinical record and requisite reporting into the PPS data system.

[131] Congruent with responsibilities to treat in the least restrictive setting.

[132] For this definition, "behavioral health hospital" shall include inpatient psychiatric units in a general hospital, free-standing Institutes of Mental Disease (IMDs), and inpatient hospital treatment for substance use disorder.

services the person would clearly have met criteria for admission to a behavioral health hospital.

A diversion does not occur if the determined need for inpatient behavioral health hospitalization is more than 48 hours before the Crisis encounter. Similarly if a Crisis program was able to effect a diversion at a given encounter but then the person is admitted to a hospital more than 48 hours later, it would still be classified as a diversion.